

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

063-038615

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 381 Primary Registration District No. 4515 Registrar's No. 82

FILED OCT 14 1963

1. PLACE OF DEATH a. COUNTY <u>SULLIVAN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>SULLIVAN</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MILAN</u>		c. CITY OR TOWN <u>POLLACK</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>SULLIVAN COUNTY MEMORIAL HOSPITAL</u>		d. STREET ADDRESS (If outside, give location) <u>POLLACK</u>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>HATTIE ETHEL CAMP</u>			4. DATE OF DEATH Month Day Year <u>OCT 4 1963</u>		
5. SEX <u>FF</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>4-26-25</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (City and state or country) <u>POLLACK MO</u>	

13a. FATHER'S NAME <u>JOSHUA CAMP</u>		13b. MOTHER'S MAIDEN NAME <u>MARY VANE THOMPSON</u>		14. NAME OF HUSBAND OR WIFE <u>GROVER SMART</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>MRS. MAE OLINGER POLLACK MO</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral aneurysm</u> DUE TO (b) <u>Senility</u> DUE TO (c) <u>-</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>-</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>-</u>	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year <u>-</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u>		20f. CITY, TOWN, OR LOCATION <u>-</u>	

21. I attended the deceased from <u>Oct. 1-13</u> to <u>Oct. 4-63</u> and last saw her alive on <u>Oct. 4-63</u> Death occurred at <u>12:30</u> A.M. on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>Ed Simpson</u>	(Degree or title)	22b. ADDRESS <u>Milan</u>	22c. DATE SIGNED <u>10-7-63</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>OCT 6, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Scobee</u>	23d. LOCATION (City, town, or county) (State) <u>Pollack MO</u>
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24. FUNERAL DIRECTOR <u>Legg Funeral Home</u>	ADDRESS <u>Milan MO</u>	25. DATE RECD. BY LOCAL REG. <u>10-7-63</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. M.W. Beckert</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

INSTEAD OF

DATE AMENDED

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

VS 300  
Rev. 4/59  
1 1050  
2 1050  
3  
4 1  
5 3  
6  
7 0  
8 0  
9 331X  
10  
11  
12 1-2  
13 2-0

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Russell R. Regan*

Licensed Embalmer No. 3792

P. O. Address Melan. Mo

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a **STUDENT**, he also shall sign in his **OWN** handwriting.

If this body is not embalmed, fact should be so stated above.